Survey of Pharmacy Benefits

prepared for

Washington State
Office of the Insurance Commissioner

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Summary and Introduction

Following an upswing in complaints about pharmacy benefits received by the Office of the Insurance Commissioner (OIC) in 1998 and 1999, we were asked to conduct a survey of pharmacy benefits available from Washington plans. A questionnaire was developed and qualified as an analysis tool in reviewing plan policies on file with OIC. A sampling plan was developed to capture representative information on three carriers based on largest enrollment, with three markets (small group, large group and individual), and three plan classifications (HMO, indemnity, and Health Care Services Contractor). For comparison purposes, three plans administered through Washington Health Care Authority (HCA) (Uniform Medical Plan, Basic Health Plan) or Washington Department of Social and Health Services (DSHS) (Healthy Options) were included.

Little differentiation was seen between plans and stratification by market or plan classification became unnecessary. Most differences that were observed related to drug benefit options available by "rider" rather than in any of the plan's basic benefit designs.

For the consumer of pharmacy benefits, differences in deductibles, copayments, formulary restrictions and pharmacy network limitations warrant attention. Only one of the surveyed plans had a deductible on the drug benefit. All of the plans use incentives to encourage the use of generic versus brand-name drugs, generally through different copayment schedules. We modeled the copayment schedule using a market basket approach and observed a seven-fold difference in copayment costs under the various plans surveyed. Many of the plans employ restrictive formularies; some provide financial incentives to encourage formulary discipline (e.g., a higher copayment for off-formulary drugs) while others reimburse for off-formulary drugs only with prior authorization. Some plans restrict access to pharmacies in their network, a potential problem for the traveling subscriber. It should be noted that some pharmacies have recently chosen to not participate in plan networks for financial reasons, and, rarely, pharmacies have been removed from networks because of quality problems.

Survey Methods

Items for the survey were gathered from several sources.

- The Office of the Insurance Commissioner (OIC) provided a report detailing complaints they had received, including: formulary problems, delay in payment, length of supply, pharmacy network limitations, denials.
- Opinion leaders were consulted for items, including an insurance broker, several employee benefits managers, pharmacy benefits managers from local insurance companies, a pharmacy benefits management company, and the author of a contemporary text on managed care and pharmacy.[1]

A draft questionnaire was circulated to many of the above opinion leaders and revised based on their input.

A sampling plan for insurers subject to regulation by OIC and providing pharmacy benefits in Washington was devised, selecting three carriers based on largest enrollment, with three markets (small group, large group and individual), and three plan classifications (HMO, indemnity, and Health Care Services Contractor). For comparison purposes, three plans administered through Washington Health Care Authority (HCA)(Uniform Medical Plan, Basic Health Plan) or Washington Department of Social and Health Services (DSHS)(Healthy Options) were included.

Plans were reviewed and the questionnaire completed to the best of the reviewers' (MB, TH and TN) abilities. Fact-to-face or telephone interviews were conducted with plan representatives to verify accuracy of the reviewers' interpretations and to resolve unanswered questions.

Responses were tabulated in as simple counts. Eight plans could be evaluated numerically. Counts in the Individual Item Response section are reported for these eight plans.

Survey Results

During the time of the survey, two selected plans became inaccessible (insolvency, left the Washington market), leaving 7 plans plus those from HCA and DSHS for review. Responses to individual questionnaire items follow this section.

Little differentiation was seen between plans and stratification by market or plan classification became unnecessary. Most differences that were observed related to drug benefit options available by "rider" rather than in any of the plan's basic benefit designs.

- Several questionnaire items addressed issues such as minimum contract duration, eligibility of dependents, etc. In all instances, the overall plan of which the pharmacy benefit was a part governed drug benefit access.

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[1] Navarro RP. Managed Care Pharmacy. Aspen, Gaithersberg, 1999.

- Only one of the plans had an annual deductible associated with the drug benefit.
- Only one of the plans required that the subscriber pay for prescriptions, with subsequent reimbursement by the plan.
- A questionnaire item addressed availability of covered disease management services (anticoagulation, diabetes, women's health, emergency contraception, etc.), and reimbursement to pharmacists for these activities. For plans where the item was germane,[2] available disease management programs were provided under another component of the plan, e.g., medical and surgical care. At present none of the Washington plans reimburse pharmacies or pharmacists for disease management programs, including emergency contraception or administration of influenza vaccine.
- Several items addressed formulary decision-making. Three plans do not have restrictive formularies, per se, though every plan provides incentives to subscribers to use generic vs. brand name drugs.
    - For plans with some sort of formulary governance,
        - some plans rely on a contract pharmacy benefits management (PBM) company for formulary decisions,
        - some plans use the PBM only for transaction processing and pharmacy network maintenance,
        - some plans are part of an organization that makes nationwide formulary decisions, but permits local implementation discretion,
        - all plans have a conflict-of-interest or voting recision requirement for formulary committee members.
- One item asked that plans rank the following in order of importance in formulary decision-making: clinical outcomes trials, cost of drug, drug efficacy, manufacturer's rebates, patient convenience, patient quality of life, patient safety, and pharmacoeconomic studies:
    - all plans denied influence of rebates on formulary decision-making;
    - all plans ranked safety and efficacy as most important, and drug cost as least important;
    - ranking of clinical outcomes trials, pharmacoeconomic studies, patient convenience or patient quality of life showed no discernable pattern.
- One item asked about the disposition of manufacturers rebates to the plan:
    - one plan indicated that the rebate was not refunded in a way that permitted any influence on premium,
    - one plan indicated that all rebates were used for premium reduction,
    - for some plans, rebates are used to reduce the cost of drugs (e.g., HMO's).

[2] The question would not be germane for an HMO where pharmacy services are integrated into the overall care package.

Individual Item Responses

1. Does the plan offer online, real-time adjudication of claims?

- All plans offer online adjudication in some format. All that is required is for the subscriber's (patient's) information to be accessible -- the subscriber's information must be "in-the-system". As virtually all pharmacies in Washington State employ electronic billing, providing the pharmacy with patient and plan identification numbers is generally sufficient to permit the pharmacy's and the plan's computers to interact, verify coverage, indicate payment owed the pharmacy, etc., with the plan.

- Patient concerns: To be "in-the-system" requires that the subscriber information regarding participation in the plan must be in the computer system of the online pharmacy benefit manager when the pharmacy attempts to bill the plan. With some insurance companies, these can be one and the same (PBM and insurer). When the PBM is a separate entity from the insurer, problems may arise if there has been poor communication between insurer and PBM. Many of the complaints received by OIC related to the breakdown of this process.

2. Is an enrollment document required as evidence of coverage?

- Most plans answered this question with an automatic "yes". However, documentation is not required in practice, as coverage status can be determined electronically. If the coverage is active, and the subscriber has not yet received the documentation, the pharmacy may enter the appropriate information into the computer in an attempt to bill for the prescription.

3. Do medications need to be ordered by a participating provider to be covered?

- Yes (2) No (6)

- Participating providers are typically either employees of an HMO, members of a practice group that contracts with the insurance plan or are individually bound by the plan to provide healthcare services to members. While the participating provider issue was clearly articulated in literature provided by the two plans that require it, it remains a source of confusion to patients. There also is the issue of referral to a non-participating specialist by the primary care provider. Authorization then must be made by the plan to allow for the medication prescribed by the specialist to be covered.

4. Are medications intended for an "off-label use" covered?

- All plans answered "yes".

- To market any drug in the United States, the pharmaceutical manufacturer must demonstrate that the drug is "safe and effective under conditions of intended use".[3] That is, the manufacturer identifies diseases for which the drug is believed to be useful, evaluates the performance of the drug in those diseases using appropriate scientific methods, and uses the results of these scientific investigations to support a "New Drug Application" (NDA) made to the U.S. Food and Drug Administration (FDA). Note that "safety" is generally evaluated *only* in the context of the diseases for which application is made. Further, a drug's "safety" is evaluated relative to the severity of a disease and to alternate therapeutic options. Thus, cancer chemotherapeutic agents may cause temporary, severe, illness in a recipient and still be described as "safe under conditions of intended use" because the likely outcome of the untreated disease is far worse than the drugs' side effects. Similarly, "efficacy" is only evaluated for the diseases for which the NDA is made. Approved safety and efficacy information is provided with the drug product's "package insert" (part of the product's "labeling"); the *Physician's Desk Reference* (PDR) replicates the package insert for the products that a manufacturer has paid to have listed.

- "Off-label" ("extra-label", "unapproved") uses are those that are not evaluated in support of the drug's NDA, and which do not appear in the package insert. Historically, manufacturers have not been permitted to promote off-label use, or even distribute information on off-label use developed by some disinterested third party.[4]

- The question of reimbursing for off-label use was raised by one of the national insurance associations in the early '90's, noting that insurers typically do not reimburse for "experimental" therapies as they cannot be held to be "reasonable and necessary" until they had been shown to work. In the ensuing controversy, a Government Accounting Office report was prepared. It suggested that better than half of prescriptions issued in the US were for off-label indications.[5]

- In most instances, an insurer will not know the intent of a practitioner in prescribing a drug product. There are, however, some unusual circumstances where off-label use may be contested. For example, a drug marketed in the US for treatment of depression, bupropion hydrochloride (Wellbutrin®), was recently marketed under a new name and differing strength (Zyban®), this time for facilitating smoking cessation. Many plans do not cover treatment of smoking cessation as a drug benefit, while other plans require that buproion use for smoking cessation include other therapies such as counseling. In

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[3] Federal Food, Drug, and Cosmetic Act

[4] This prohibition has recently been challenged in court: 63 Federal Register 64556. CFR 16 & 99, Dissemination of Information, final rule (11/20/98)

[5] Prescription Drugs: Implications of Drug Labeling and Off-Label Use. Government Accounting Office, 1996, T-HEHS-96-212

theory, a practitioner could prescribe bupropion for smoking cessation under the Wellbutrin® name and evade the plan's intent.

- See also the item on categorical exclusions, Item { REF _Ref484251397 \r \h }.

5. Are Newborns automatically covered under the drug benefit?

- Yes (4) No (4)

- Those that did answer with a negative response (i.e., newborns not automatically covered) have a written provision to provide initial neonatal care. All plans expressed at some point the need for the members with new children to enroll them either at the next open enrollment or within a grace period.

6. Are there dispensing supply limitations for medications?

- Day's Supply (7), Quantity (6), Other (1)

- Typically 30 - 34 days supply or 100 dose units (tablets or capsules); 90-100 days supply for "chronic" conditions such as diabetes or hypertension

- Patients do not want to make too many trips to the pharmacy and would prefer longer dispensing cycles, especially those that travel. Insurers do not want to reimburse for drugs that may go unused because of patient intolerance or dosage change. Some drug quantities may be limited through safety concerns with excess use (i.e., some migraine therapies).

- Some plans provide an incentive to subscribers using chronic medications to obtained them from a mail-order pharmacy rather than locally.

- Washington law limits prescription refills to one year from the date of the original prescription.[6]

- Plans will typically not reimburse for "early refills". When the plan is billed by the pharmacy for a medication, one of the data elements in the billing record is the estimated days supply. For a tablet that is taken once daily, this number is straightforward – 30 for a 30-day supply. For medications such as hand-held aerosols where the number of doses is approximate (see albuterol or ipratropium in { REF _Ref483368571 * MERGEFORMAT }), or where the drug is used on an

[6] WAC 246-869-100 (2)(d) Prescription refill limitations

"as needed" basis, a patient may run out of the drug before estimated days supply has elapsed. The subscriber may be expected to pay for the "extra" dispensing of the drug, and delays are sometimes encountered if no additional refills have been authorized by the prescriber.

7. Must prescription medications be filled at a participating plan pharmacy to be covered? Yes (5) No (3)

- One aspect of pharmacy benefits administration is assurance of pharmacy access and quality to patients or client insurers. A pharmacy benefit is of little use if there are no accessible pharmacies and some insurers assess patient satisfaction (or other quality measures) with pharmacies. In developing networks of participating pharmacies, financial agreements are established, including the reimbursement structure from the plan to the pharmacy, and electronic billing linkages.Patients using non-participating pharmacies may need to pay cash at the pharmacy and seek reimbursement from the insurance plan. Some plans provide financial incentives to use in-network pharmacies, e.g., a lower copayment.Some plans restrict areas of coverage (e.g., Washington State only). Some pharmacies do not participate in insurance reimbursement because of cost of participation (reduced reimbursement compared to cash, time costs in resolving problems) is felt to be burdensome. Some pharmacies have been eliminated by insurance plans because of quality problems. **Is access to medications restricted by a formulary?**

- Yes (5) No (3)

- *Open formularies* typically include virtually all available *prescription* [7] medications approved by the FDA, but may not include drugs approved in foreign countries that lack FDA approval, non-prescription drugs, nutritional supplements, or therapies for conditions not covered by the plan, e.g., smoking cessation.

- A formulary is a list of drugs chosen (in this case) by the plan or pharmacy benefits manager. With *restricted, limited* or *closed* formularies, a plan will either not reimburse for an off-formulary claim, or may offer financial incentives to favor the formulary selection, e.g., a reduced co-payment for an on-formulary vs. an off-formulary drug.

9. Typical Copayment Schedule

There is considerable variability in the copayment schemes available between and among plans. For most of the commercially available plans, different copayment schedules are available as riders to the to the drug benefit. With many plans, the drug benefit

[7] Under US law, a drug is assigned prescription-only status if it is (a) habit forming, (b) intrinsically so unsafe that its use and assessment of clinical outcomes must be managed by a licensed practitioner or (c) the preference of the manufacturer. Durham-Humphrey Amendments to the Food, Drug and Cosmetic Act. Ch. 578, 65 Stat. 648 (1952)

is available as a rider, and a selection of copay schedules is available to the purchaser. A selection of copayment schedules is presented in { REF _Ref483376460 \h * MERGEFORMAT }. For example, if a subscriber to Plan 1 received a prescription for a generic drug, her copayment would be $10 for a 30 day supply or $20 for a 90 day supply. A subscriber to Plan 3 receiving a prescription costing (under the pharmacy's negotiated reimbursement structure) $12.00 would pay the entire amount (copayment schedule: <$15); for a prescription costing $111.78, the subscriber's copayment would be 50%, or $55.89. A subscriber under Plan 6 receiving a prescription for a non-formulary drug would pay a $50 copayment for a 90 day supply. A Basic Health Plan Medicare subscriber would pay $5 for a 30 day supply for a "Tier 2" generic drug, but 50 % of the prescription's cost for a brand name drug.

10. Do formulary changes that restrict access to medications become effective during the term of the contract?

- Yes (5) No (3) The three plans responding "no" do not have restrictive formularies.
- Plans with restricted formularies typically change the formularies to accommodate (a) introduction of new drugs, (b) removal of drugs because of safety or efficacy questions, and (c) to reflect contractual changes with drug manufacturers. As these changes occur continuously, the plan's formulary is subject to continuous change.
- A question that is often raised in the context of formulary changes is that of disrupting a patient's otherwise stable treatment regimen: if the drug was "working", why change it?
- In some instances, change is beyond the plan's control, as with market withdrawal of drugs found to be "unsafe"; recent examples include troglitazone (Rezulin®) and cisapride (Propulsid®).
- In some instances, the change involves drugs thought to be therapeutically interchangeable for most patients. For instance, the patent recently expired on ranitidine (Zantac®). Several plans encouraged prescribers and patients to switch from the brand name drugs Zantac®, Pepsid® or Axid® (drugs in the same therapeutic class, with similar therapeutic and safety profiles) to generic ranitidine because of the substantial savings available to the patient and the plan. Typically, the plan will contact both prescriber and subscriber to request the change. In some instances, the pharmacy may request that the patient consider the change.

11. Do you assess patient satisfaction with pharmacy services?

- All plans assess quality of pharmacy services as part of an overall plan survey program.

12. Is the plan formulary available to all potential or actual subscribers?

- Some plans maintain web-sites providing formulary information.

- Patients typically want to know if their maintenance medication is on the formulary or not. All plans will provide full formulary copies via mail or answer questions over telephone.

- Most plans announce formulary changes via a monthly newsletter, and contact individual patients via letter if access to a medication that they have been using chronically might change.

- Confusion over formulary restrictions has substantially increased the "hassle-factor" for all participants in the prescribing chain. With insurance plans having differing formulary restrictions, prescribers are often unaware that a drug with which they have developed significant experience may be unavailable. The patient often finds that a drug is not covered when receiving a prescription at a pharmacy, and is asked to pay cash – sometimes hundreds of dollars – for the medication. The pharmacist would like to focus on his/her area of professional competence, drug therapy, but is expected to "fix" the reimbursement problems, contact the prescriber to change the drug, or obtain justification for the "off-formulary" drug. The time costs for resolving these reimbursement issues for prescriber and pharmacy are substantial and for which no reimbursement from the plan is available. National Association of Chain Drug Stores' recent study of the time distribution of pharmacists' tasks showed that pharmacists spent more than 20 % of their time resolving "insurance problems", time that could be better spent assisting patients with their drug therapy.[8]

13. Is coverage provided for compliance packaging services for persons with special needs.

- "Compliance" packaging provided by the pharmacy includes repackaging a medication is a way that improves patient compliance (regimen adherence). For instance, drugs could be repackaged into a "Medi-sets", a multi-chambered box with individual compartments for each day of the week, and multiple dosing times for each day. Compliance packaging may be helpful for a patient with a complex medication regimen, or one who has had difficulty remembering to take her drugs according to the intended regimen. Some plans require prior authorization for reimbursement for compliance packaging.

Plans Reimbursing Pharmacies For Compliance Packaging	
Special packaging for visually impaired	4
Special labeling for visually impaired	5
Pre-filled syringes for disabled diabetic patients	6

[8] Pharmacy Activity Cost and Productivity Study. Arthur Anderson. National Association of Chain Drug Stores Education Foundation. 1999.

Special packaging services for elderly	4

14. Plans were asked to identify any drugs for which categorical restrictions were identified.

Results:

- AIDS therapies – 0
- Allergy Symptom Treatments – 3
- Anorexiants (weight loss aids) – 7
- Biological sera, blood derivatives (typically covered under another benefit) – 3
- Contraceptive devices/drugs – 4
- Medications provided at discharge from a hospital ("discharge meds") – 4
- Erectile dysfunction – 7
- Fertility drugs – 8
- Growth hormone (off-label) – 6
- Hair growth stimulants - 8
- Herbal remedies - 6
- Naturopathic remedies (other than prescription drugs for which the naturopath has prescriptive authority) - 5
- Onychomycosis - 5
- Prenatal vitamins - 1
- Prescription anti-wrinkle cream – 7
- Smoking cessation (may be covered under another benefit) - 3

Discussion: The majority of these categories deal with cosmetic and lifestyle concerns. All plans have exception policies for treatments that are considered to be medically necessary.

15. Is coverage provided for prophylactic immunizations and medications for foreign travel.

- Yes – 1, No – 7

16. Is coverage provided for medications that have not been approved by the US FDA.

- Yes – 0, No - 8

- FDA approval is a litmus test for "reasonable and necessary". If a drug has not received FDA approval, information about safety and efficacy is usually not available.

17. Is coverage provided for drugs and/or associated supplies available only through an effective Investigational New Drug Application (IND)?

Plans Providing Coverage For Investigational Drugs And/Or Associated Supplies	
Phase 1 – 1	Phase 2 – 2
Phase 3 – 2	Phase 4 – 4

- **Discussion:** Although not all of the plans cover for Investigational Drugs, the likelihood of coverage increases as phase and confidence level for the drug increases.

18. Is coverage provided for diabetes therapy?

- All plans cover equipment and supplies specified in RCW 48.44.315 (2)(a) Diabetes coverage.

19. Is coverage provided for immunizations/administrations?

- Neonatal/childhood – 8
- Adolescent – 8
- Adult - 8

20. Subscriber Out-of-Pocket Costs for Covered Drugs

Mrs. (Jewel) Brown's Drugs. In November 1998, *Wall Street Journal* published a series of articles under the banner "Hard To Swallow". One of the articles described Mrs. Brown's medications and their monthly cost.

> "... some months Mrs. Brown spends up to $400 for medications, more than 30% of her income. Prilosec calms her stomach but sets her back $102.59 for a 30-day supply. Then there are Norvasc for her blood pressure ($43), two inhalers to help her breathe easier ($88 total), two pain medications ($70), nitroglycerin patches for angina ($27.89) and Theophylline to clear her lungs (a bargain at

> $16.37). Recently, her doctor prescribed Miacalcin, a nasal spray that helps strengthen her bones but depletes her purse by $55.43 a month".[9]

We have used Mrs. Brown's medication profile to model the monthly costs for medications using typical copayment schedules available from the insurance plans. Note that no therapeutic conclusions should be drawn from the profile. For instance, it is likely that equally effective though less expensive medications could be substituted for some of the listed medications.

{ REF _Ref483368571 \h * MERGEFORMAT } provides information on the medication profile. The estimated 30-day supply cost is provided for:

- typical reimbursement schedule from an insurance company to a pharmacy (column 9)[10]
    - $346.91 using generic drugs when available; $401.45 using only brand-name drugs
- typical cash price a patient would pay (column 10)[11]
    - $413.65 using generic drugs when available; $475.63 using only brand-name drugs
- typical cash price (in US dollars) a patient would pay in British Columbia (column 11)[12,13]
    - $200.98 using generic drugs when available; $290.20 using only brand-name drugs

{ REF _Ref483370888 \h * MERGEFORMAT } shows estimated subscriber out-of-pocket expenses for Mrs. Brown's drugs using typical copayment schedules from each of the plans with copayments.

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[9] from "Hard to Swallow -- America's Soaring Drug Costs --- The Uncovered: Drug Costs Can Leave Elderly a Grim Choice: Medicines or Necessities --- When a Trip to the Pharmacy Costs $400, and Medicare Doesn't Pay for Any of It --- Buying"; Lagnado L; *Wall Street Journal*; Nov 17, 1998; Eastern edition; pg. A.1

[10] The cost of a prescription is typically the sum of the "ingredient cost" and a "dispensing fee". We have modeled the ingredient cost using a 12 % discount from Average Wholesale Price, a published price schedule for drugs sold in the US, and a dispensing fee of $2.50. AWP-12% + $2.5 is a typical reimbursement schedule for pharmacies in Washington.

[11] Modeled as AWP + $5.

[12] International drug price comparisons must be made with caution. See, for example, Danzon PM, Kim JD. International price comparisons for pharmaceuticals. Measurement and policy issues. Pharmacoeconomics. 1998;14 Suppl 1:115-28.

[13] Under Canadian Food and Drugs Act and Regulations, Canadian pharmacies can only honor prescriptions written by practitioners authorized by a province to prescribe.

- The lowest average daily out-of-pocket copayment expense for Mrs. Brown's drugs is about $1 while the highest is about $7.
- Using only brand name drugs can double or triple the copayment.
- Some plans encourage use of mail order pharmacies for subscribers using drug for chronic conditions such as hypertension. With some plans, the daily copayment charge averaged 30 percent less for mail-order vs. estimated community pharmacy charges.

Discussion

Peculiar drug benefit options available from one plan but not another may be important to a subscriber. Reviewing plan's descriptions and asking questions about drug availability and out-of-pocket expense for a "market basket" of drugs, such as Mrs. Brown's drugs example, that a subscriber uses regularly will assist in selecting the best value for an individual consumer.

- Most plans provide the best value (e.g., minimum copayment) when generic drugs are used and some plans provide costly incentives to avoid brand name drugs when generic substitutes are available. Subscribers with chronic diseases whose therapies involve brand-name-only drugs should consider plans whose copayment structure is least costly for brand name drugs.
- Some plans do not provide out-of-area coverage, a service that might be important to subscribers that travel a lot.
- Subscribers should be sure that participating pharmacies are easily accessible.
- While none of the plans reviewed had caps for the pharmacy benefit (a growing trend), drug therapy might be linked to a service with a cap.

Table { SEQ Table * ARABIC } Copayment Schedules

		Plan 1		Plan 2		Plan 3		Plan 4		Plan 5		Plan 6		Plan 7		Basic Health Plan[a]	
30 Day Supply	Tier 1	Generic	$10	Formulary	$10	<$15	charge	Generic Formulary	$5	Generic	$5	Formulary Generic	$5	Generic	10%	Tier 1 Formulary	$1
	Tier 2	Brand	$20			$15-30	$15	Brand Formulary	$10	Brand	$15	Brand Name Formulary	$10	Brand	30%	Generic Drugs not in Tier 1	$5
	Tier 3					>$30	50%	Non-Formulary	$25			Non-Formulary	$25	Brand with Generic Equivalent	50%	Brand Name Drugs	50%
90 Day Supply Mail Order Only	Tier 1	Generic	$20	Formulary	$30	<$15	charge	Generic Formulary	$10	Generic	$5	Formulary Generic	$10	Generic	$20		
	Tier 2	Brand	$40			$15-30	$15	Brand Formulary	$20	Brand without Generic Equivalent	$15	Formulary Brand	$20	Brand	$30		
	Tier 3					>$30	50%	Non-Formulary	$50	Brand with Generic Equivalent	$30	Non-Formulary	$50	Brand with Generic Equivalent	$40		

Notes:

Brand -- copayment for brand-name drugs

Brand Formulary -- copayment for brand-name drugs listed in the plan's formulary

Brand with Generic Equivalent -- copayment for brand name drugs for which a generic equivalent is available; for example, Vicodin (hydrocodone/APAP)

Brand without Generic Equivalent -- copayment for drugs that have no generic equivalent; for example, Prilosec (omeprazole)

Formulary -- copayment drugs listed in the plan's formulary

Generic -- copayment for generic drugs

Generic Formulary -- copayment for generic drugs listed in the plan's formulary

Non-formulary -- copayment for a drug *not* listed in the plan's formulary

[a] Tier 1 vs. Tier 2 formulary composition is determined by individual plans

Table { SEQ Table * ARABIC } Mrs. Brown's Drugs – Profile Using Generic and Brand Name Drugs

Notes: 1	2	3	4	5	6	7	8	9	10	11
Indication	Brand Name	Generic Name	Drug Strength	Maximum Doses per Day	SIG	Quantity per 30 Days	AWP each Cardinal 05/18/00	30 days AWP-12% +$2.50	30 days AWP + $5	30 days BC Pharmacare DMF + $CDN 7.5 @ 0.6883
Calms her stomach	Prilosec	omeprazole	20mg	1	1 daily	30	$4.14	$111.78	$129.18	$50.59
Blood pressure	Norvasc	amlodipine	5mg	1	1 daily	30	$1.33	$37.68	$44.98	$31.59
To help her breathe easier	generic	albuterol inhalation (same as salbutamol)[12]	90mcg/ACTIV/17gm	12	2 every 4-6 hours as needed	1	$21.70	$21.60	$26.70	$20.38
To help her breathe easier	Atrovent	ipratropium inhalation	18mcg/ACTIV/14gm	8	2 four times daily	1	$38.87	$36.71	$43.87	$16.90
For pain	generic	hydrocodone/APAP (oxycodone/APAP)[13]	5-500mg	6	1 every 4-6 hours as needed	90	$0.16	$15.30	$19.55	$11.11
For pain	generic	ibuprofen	400mg	3	1 three times daily	90	$0.12	$12.00	$15.80	$7.47
Angina	generic	nitroglycerin transdermal	0.4mg/hr	1	1 daily	30	$1.58	$44.21	$52.40	$18.38
Clear her lungs	generic	theophylline-SR	200mg	2	1 twice daily	60	$0.16	$11.16	$14.84	$10.74
Strengthen her bones	Miacalcin	calcitonin nasal spray	200IU/ACTIV/2ml	1	1 daily	2	$30.67	$56.48	$66.34	$33.84
TOTAL CHARGE FOR 30 DAY SUPPLY USING GENERIC DRUGS WHEN AVAILABLE								$346.91	$413.65	$200.98
To help her breathe easier	Proventil / Ventolin	albuterol inhalation	90mcg/ACTIV/17gm	12	2 every 4-6 hours as needed	1	$30.12	$29.01	$35.12	$20.38
For pain	Vicodin (Percocet)	hydrocodone/APAP (oxycodone/APAP)[13]	5-500mg	6	1 every 4-6 hours as needed	90	$0.50	$42.04	$49.94	$73.61
For pain	Motrin	ibuprofen	400mg	3	1 three times daily	90	$0.13	$12.62	$16.50	$17.56
Angina	Transderm-Nitro	nitroglycerin transdermal	0.4mg/hr	1	1 daily	30	$1.96	$54.13	$63.67	$14.14
Clear her lungs	TheoDur	theophylline-SR	200mg	2	1 twice daily	60	$0.35	$21.01	$26.04	$31.59
TOTAL CHARGE FOR 30 DAY SUPPLY REPLACING GENERIC DRUGS WITH LISTED BRAND NAME DRUGS								$401.45	$475.63	$290.20

Notes

1. Indication: the reason Mrs. Brown is using the drug
2. Brand Name: the brand name under which the drug is marketed in the United States; note that some brand names differ in Canada
3. Generic Name: the chemical name of the drug used in the United States; note that some chemical names differ in Canada
4. Drug Strength: the strength of each tablet, capsule, etc., ACTIV = activation ("squirt") for hand-held aerosol drugs; transdermal patches show milligrams per hour
5. Maximum Doses per Day: typical use of the drug
6. SIG: typical instructions for use of the drug
7. Quantity per 30 Days: estimated quantity that would be used in 30 days
8. AWP EACH: the published Average Wholesale Price for each dose or dispensed item (e.g., hand-held aerosol drug) as of 5/18/2000
9. 30 days AWP-12% + $2.50: estimated reimbursement to a pharmacy under a typical insurance agreement
10. 30 days AWP + $5: typical cash price
11. 30 days BC Pharmacare DMF + $CDN 7.5 @ 0.6883: estimated cash price (in US dollars) if the prescription was filled in British Columbia (BC); does not include the charge for a physician's office visit required in BC; data obtained from BC Pharmacare Drug Master File; a $CDN7.50 dispensing fee per prescription was assumed; exchange rate of $0.6883/$CDN; US Customs/FDA/Drug Enforcement Administration regulations may limit quantities; see http://www.customs.treas.gov/travel/meds.htm
12. Canadian generic name for albuterol is salbutamol
13. Hydrocodone/APAP (acetaminophen) is not marketed in Canada; a similar drug (oxycodone/APAP) has been substituted for the BC price calculation for comparison purposes only

Table { SEQ Table * ARABIC } Mrs. Brown's Drugs -- Monthly / Quarterly Charges by Plan

	Estimated Cash Price	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7	Basic Health Plan
30 day supply using generic drugs when available	$414	$130	$90	$197	$40	$85	$65	$83	$146
30 day supply using only brand name drugs	$476	$180	N/A	$212	$95	$135	$90	$152	$200
90 day supply using generic drugs when available; mail order only	$1,151	$260	$270	$458	$80	$85	$130	$210	N/A
90 day supply using only brand name drugs; mail order only	$1,337	$360	N/A	$580	$190	$210	$180	$310	N/A

N/A - not applicable